

REPORT OF A CASE OF INTRACRANIAL TRIFACIAL NEURECTOMY.¹

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MRS. S., German, aged sixty-four, mother of ten children, came to me in September, 1893, suffering from severe, intractable, trigeminal neuralgia, right side; the full limits of the three divisions were involved. The disease had four years' duration. At first intermittent, and most severe in the second division. After a year the paroxysms lengthened so as to become almost continuous. Her general health had become very much impaired by reason of loss of sleep and failure of nutrition. Under treatment she improved and the local symptoms became markedly less severe. Notwithstanding her improvement, I advised intracranial neurectomy with an effort to remove the Gasserian ganglion. This was declined, and in the fall she returned to her home at Put in Bay. In July, 1894, she again came, and this time asked for the operation. The winter's experience, shut in from the outer world, made her willing to undergo any operation that offered relief. She was ready to take all chances, submit to anything, preferring death to the life she had lived during the past winter. Accordingly on August 11, 1894, her general health having again much improved under treatment, I performed the operation. Following the plan devised by Dr. Frank Hartley, of New York City, I made an omega-shaped incision, beginning at the external angular process of the frontal bone, right side, and extending at the crown of the arch to three and a half inches above the zygoma, and thence down to or in front of the tragus of the ear. The base corresponding with the line of the zygoma was not divided. The incision in its whole length was carried down to the bone. This was next divided along the line as above described by a chisel, known among carvers as a parting tool. The cutting edge was V-shaped, and the same as used by Dr. Hartley. The vitreous plate was in the main divided by

¹ Read before the Toledo Medical Society.

a smaller blade of same shape. Along the crown of the arch it was cut through and the carf opened wide enough to admit a heavy, plain-faced bone-chisel, which, used as a lever, pried the circular piece of bone off from the dura, fracturing it at the base. This, though a forcible effort, was done with considerable care to save intact, if possible, the middle meningeal artery, which we so often find embedded in the bone, in some instances tunnelling it. Care is necessary here, because by rougher effort a rupture may be made, which, of course, adds to the embarrassments of the operator. In this case the vessel, well defined, was not ruptured. The separated bone with the integument muscle covering was turned outward and down upon the cheek. I carefully raised the dura and brain from the middle fossa of the skull. Here I met with a condition for which I was unprepared. During a large experience in skull- and brain-work I had uniformly found the dura possessed of some considerable strength of tissue, but here it was thin and soft. In the effort at elevation it was several times perforated by my finger. Aside from this there were few or no hinderances. A light escape of blood, which was easily controlled by gauze pressure. The division and removal of the nerves accomplished, the brain was allowed to settle into the fossa. The bone with its soft covering was restored to place, sutured, and the patient returned to her bed. The main difficulty attending the operation was the loss of blood, which was very great, from the incision and external covering of the skull, the greatest I had ever met with in operations upon the head. Added to this were those attending the use of the anæsthetic. Dr. Chapman, to whom was assigned this important work, notified me several times to be as expeditious as was compatible with the operation, as the patient was doing badly. The ganglion was not entirely removed for reasons readily understood by those doing such work. Time required, one hour and forty-three minutes from beginning to finish. I am greatly indebted to Drs. Collamore, Duncan, Chapman, and Becker for valuable assistance. Dr. Hasenkamp was also present.

August 12. Patient has rested well; no pain. Dressings being soiled by oozing were renewed under proper precautions.

August 13. Patient's temperature, $101\frac{1}{2}^{\circ}$ F.; no pain.

August 15. Aside from some functional derangements, hallucinations, everything was very promising. No temperature; no pain.

August 16. The hallucinations still continuing without pain, sleeplessness, or temperature, I suspected the condition might depend upon iodoform absorption.

August 18. Dressing changed, all iodoform removed, and boracic dressings substituted.

August 19. No temperature; no pain; sleep good. Hallucinations less marked. Ordered iron and quinine.

August 20. Condition improving. Hallucinations subsiding.

August 23. Hallucinations absent. Dressings removed. Wound practically closed. No pus thus far.

August 26. Patient discharged cured.

Operation was made at St. Vincent's Hospital general operating room.

September 12. Patient seen this day. Cure is complete. She is entirely free of pain. Nothing now remains except slight ptosis, which has continued since time of operation, though now almost recovered from. This, I believe, is the first time this operation has been performed in this State, Ohio.

December 15. Reports from patient show no return of pain. Ptosis practically recovered from.